FORM APPROVED

Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TN6901 | A. BUILDING: _____ B. WING _____ | 07/08/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PICKETT CARE AND REHABILITATION CENTE | 129 HILLCREST DRIVE BYRDSTOWN, TN 38549 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 000 | Initial Comments<br><br>An annual Licensure survey and complaint investigations #35869, #36205, and #33630 were completed on July 8, 2015, at Pickett Care and Rehabilitation Center. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes. | N 000 | | |

on of Health Care Facilities

RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kristie Johnson Kristie Johnson — TITLE: Admin Administrator — (X6) DATE: 7/28/15 7/27/15

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